National Centers of Excellence
in Women's Health

National Forum

November 1-2, 1999
Washington, DC

Executive Summary

Office on Women's Health
U.S. Department of Health and Human Services

January 2000

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INTRODUCTION

This report summarizes the proceedings of the first Forum of the National Centers of Excellence in Women's Health (CoE). With federal funding, these Centers of Excellence, located at leading academic health institutions, are integrating advances in women's health research, professional training, public health education, clinical services, and community outreach, along with fostering the recruitment, retention, and promotion of women in academic medicine. The Forum was designed to share information and findings among the CoEs and with representatives of other academic health centers interested in adopting the CoE model or its components.

The National Forum was jointly sponsored by the Office on Women's Health (OWH) within the U.S. Department of Health and Human Services (DHHS) and the Association of Academic Health Centers (AHC), a national, non-profit organization that represents more than 100 academic health centers nationwide. It was held on November 1-2, 1999, at the Renaissance Washington Hotel, in Washington, DC.

A conference planning group, consisting of representatives from each of the National CoEs and OWH staff members, developed the content and format of the National Forum. The Forum featured opening remarks, two plenary sessions, a luncheon address, and a series of 31 workshops organized into six tracks—clinical care, research, professional education, leadership, partnerships and alliances, and community and patient education—representing essential components of the CoE program. Crosscutting themes of core concepts, financial issues, underserved populations, and information technology were addressed in each track.

This summary report presents the full proceedings of the general sessions and a summary of each workshop track. A listing of presenters is provided in Appendix 1.

OPENING REMARKS

Opening remarks were offered by **Wanda K. Jones**, Dr.P.H., Deputy Assistant Secretary for Health—Women's Health, and **David Satcher**, M.D., Ph.D., Assistant Secretary for Health and Surgeon General.

Dr. Jones offered a brief history of the CoE program initiated in 1996, noting that the National Forum was designed to showcase the CoEs' accomplishments and assist other institutions in adapting the CoE model to their communities. She stated that the Center of Excellence in Women's Health program views women as more than a collection of reproductive organs. Each Center of Excellence serves the whole woman and her community with a comprehensive array of health services. It contributes to much needed research in women's health, reaches out to local women who are underserved, and recognizes that only by promoting women (including minority women) to leadership positions will the health care work force and system truly reflect the changing face of health. Dr. Jones thanked each of the CoE directors for their efforts and acknowledged the contributions of the Association of Academic Health Centers, which brought together a diverse array of supporters to help make the Forum possible.

Dr. Jones provided a historical overview of women's health. She noted that 150 years ago women were unwelcome in academic medicine and women as patients were also neglected. There was no concept of prenatal care. Women's health was viewed only in the context of women's reproductive organs and there was a widespread view that women's attempts to develop their brain would compromise their ability to bear children. She stated that at the beginning of the 20th century, a woman often did not live past her 48th birthday. Women were threatened by tuberculosis, other infectious diseases, and complications from childbirth.

Dr. Jones then highlighted some of the many advancements in women's health that have been made in this century, and particularly in the past decade, when the notion of truly comprehensive health care for women has become pervasive. She also addressed future trends in women's health, including issues related to the aging of the American population. Dr. Jones noted that in 30 years, 1 in 4 American women will be over the age of 65. The number of women living past the age of 85 is expected to triple. In addition, the racial and ethnic makeup of the American population will also change. Approximately 1 in 5 American women will be of Hispanic heritage; 1 in 8 will be African American; 1 in 11 Asian; and 1 in 100 American Indian.

Dr. Jones noted that to address the changes and challenges facing women's health in the next century, the Centers are developing standards of excellence in women's health care, training, and education. They are also helping women take more responsibility for their own health through active patient education and outreach, and by making use of new emerging communication technologies. Dr. Jones concluded by providing several examples of innovative programs being conducted by CoEs nationwide, which were described in greater detail during the workshop sessions conducted later in the conference.

Dr. Satcher opened his address by recognizing the CoEs as truly pioneering centers that are improving the quality of health care for women across the nation. He said it was very encouraging to see how much the centers had accomplished in just a few years. He also welcomed attendees who were not a part of the CoE program and expressed the hope that they would gain ideas useful in their communities.

Dr. Satcher spoke of the important role of the academic health centers in advancing the health of the nation and in meeting the Public Health Service goal of addressing the racial and ethnic disparities in health care access and outcomes. He mentioned that Healthy People 2010, which outlines the nation's public health goals for the next decade, has two major aims: to increase the span of healthy years for American people and to increase the quality of life at every stage of the life span.

He described the U.S. Department of Health and Human Services (DHHS) initiative that is targeting several priority areas that are relevant to the work of the CoEs, including infant mortality, cancer, cardiovascular disease, HIV / AIDS, immunizations, and diabetes. Dr. Satcher provided several examples of existing disparities in the incidence of particular diseases and treatment outcomes for different racial and ethnic groups.

Dr. Satcher stressed the need to place a greater emphasis on prevention. He referred to the Nurses Health Study, conducted by the Harvard School of Public Health, which has tracked the health of more than 84,000 nurses over 20 years. The study has linked physical activity with a reduction in risk for breast cancer and diabetes.

Dr. Satcher stated that one of DHHS's highest priorities is to move towards "a balanced community health system that focuses on health promotion and disease prevention." Americans currently spend about $1.3 billion a year on their health system, with about 90 percent being spent on the treatment of diseases. There is a need to focus on health promotion, prevention, the early detection of diseases, and universal access to care.

Dr. Satcher noted that the health systems of the future must involve all institutions in the community which can contribute to the health of the people in that community. He referred to the Safe Schools and Healthy Students initiative, a community-based program jointly sponsored by DHHS, the U.S. Department of Education, and the U.S. Department of Justice, which is being conducted in 54 communities across the country.

As resources are limited, there is a need for innovation and for the development of partnerships. Dr. Satcher lauded the efforts of the CoEs, which have been able to leverage more than $82 million for women's health activities. He stated DHHS's commitment to continue to work with the CoEs as partners.

Dr. Satcher also mentioned the many advances in health that have been made in the last century. These include the increase in life expectancy from 47 to about 77, the control of many infectious diseases, decreases in lead poisoning, reductions in car crashes and injuries as a cause of death, and the decline in homicides. However, he also identified some of the growing health concerns as we enter the next century. These include the dramatic increase in asthma among children and of physical inactivity among Americans in general. Obesity, including child obesity, is increasing, and diabetes is at an all-time high. There is an increasing incidence of Type 2 diabetes among children under 10 years of age.

Dr. Satcher noted that disparities in health continue to exist and that the system is out of balance. He challenged participants to work together to build a new system for themselves and for their children.

PLENARY A

National Centers of Excellence: Innovative Models for Advancing Women's Health

Nancy Milliken, M.D., Director of the National Center of Excellence in Women's Health at the University of California, San Francisco, presented the first plenary session, which was moderated by **Margaret McLaughlin**, Ph.D., Director of the CoE at Magee Womens Hospital.

Dr. Milliken opened by saying it was an honor to represent the Centers of Excellence at this plenary session. She noted that academic health centers are now being viewed as leaders in advancing women's health. She stressed the importance of the women's health care movement, which served as the catalyst for the many advances that have been made in women's health.

Dr. Milliken noted that the CoEs were established to address inequities in women's health. These include the inadequate attention to gender differences, the exclusion of women from research studies, the lack of funding for women's health, reduced access to health care for all women, the lack of education on women's health, and the dearth of women in leadership positions.

She stated that in the early part of this decade several initiatives were implemented to begin to correct some of these inequities. The first was the establishment of guidelines within the National Institutes of Health (NIH) for the inclusion of women and minorities in research studies, accomplished in 1990. Subsequently, several government agencies, including NIH's Office of Research on Women's Health (ORWH), the Food and Drug Administration, and the Centers for Disease Control and Prevention contributed to the development of a national research agenda for women's health. With the recognition of the importance of integrating women in the activities of the Department of Health and Human Services, it developed women's health offices in each of its major offices and agencies. The DHHS Office on Women's Health was developed to coordinate all the women health activities across the department. Regional and State offices of women's health were also established.

Despite the many accomplishments made in the early 1990's, several deficiencies remained. Few academic health centers actually provided integrated health services. There were still major gaps in research on gender differences in the etiology, treatment, and prevention of diseases

that were unique or more prevalent in women. In addition, professional education still did not focus on gender differences in health and disease.

It was at this point that the DHHS Office on Women's Health recognized the important role that academic health centers could play in correcting these inequities. Dr. Milliken noted that the goal of the CoEs is to transform traditional academic medical centers into model women's health programs that integrate research, clinical care, education initiatives, leadership, and community outreach, allowing them to focus more effectively and dynamically on women's health.

Dr. Milliken described academic health centers as typically having three divisions: research, education, and clinical care. There is often a lack of coordination among the goals of each division, which results in fragmented, narrowly-focused clinical and research efforts on behalf of women, and teaching that has perpetuated a lack of knowledge and erroneous assumptions about women.

This lack of coordination also results in several other shortcomings. Research has primarily focused on basic science, there is a lack of communication and collaboration among the various research disciplines, findings have not been widely disseminated, and there has been an inadequate translation of research into clinical practice. Issues within clinical care have included the fragmentation of care, the use of a male model, the provision of care by multiple providers with little coordination among them, and a lack of attention to patient satisfaction. Teaching has been narrowly focused on provider education, women's health issues are still seen as relating to reproductive organs, and it is still assumed that research conducted with men is applicable to women. In addition, limited attention has been devoted to communication styles and to patient education, and there has been insufficient involvement in public or policy education.

Dr. Milliken stated that the CoEs are trying to change this paradigm—to transform academic institutions into dynamic centers for women's health. She then provided an overview of the University of California, San Francisco (UCSF) CoE model, which has five core components: research, clinical care, professional education, leadership development, and community involvement.

In *research*, UCSF is attempting to enhance the focus on women's health. A local research agenda must be developed as a collaboration between the community and the scientific community. The community can help identify gaps that should be addressed through research, and information

obtained through the research must be disseminated to the community. There should also be a link between research and clinical care, and research findings should be moved to the educational arena.

Within *clinical care*, there is a need to develop models of integrated primary care in order to provide comprehensive and gender-specific health care for women. Dr. Milliken noted that women are consumers of care who interface with the system on a frequent basis. The goal should be to create seamless pathways between the primary, secondary, and tertiary care nodes. She also noted the importance of developing clinical partnerships, conducting focus groups with consumers, focusing on patient and community education, and gauging patient satisfaction.

Within *professional education*, the goal should be to develop women's health curricula across all levels of professional training. The goal is to incorporate the new scientific knowledge on sex and gender differences into the curriculum. This will ensure that our providers of tomorrow are adequately trained to counsel and treat women as well as men.

Leadership development is another core mission of the CoEs. It is important to have effective voices in powerful positions to sustain the CoEs' vision for women's health. Leadership development should include staff and students. The goal is to develop and cultivate women leaders to enrich the pool of decision makers. Attention must be given to recruitment, retention, and promotion. Leadership efforts should also include conducting mentoring in clinical care, research, and education; and encouraging young women and men from diverse communities to pursue careers in women's health.

The academic institution must be aware of its place within a larger community if it is truly to advance women's health . *Community involvement* must be a part of everything a CoE does. Dr. Milliken stressed that the development of community partnerships requires time and commitment, trust, respect, reciprocity, and an understanding of shared goals.

Dr. Milliken acknowledged that changing the paradigm is a challenge for the academic health center. She noted that while the vision is multidisciplinary, the departments work independently of each other. As a result, it is necessary to identify catalysts for change, such as institutional leadership, external validation, public demand, and grassroots leadership.

Institutional leadership can include chancellors, deans, a system's CEO, or others in leadership positions who are interested in creating a unified, integrated health system that transcends the more departmentally-driven practices. Dr. Milliken noted that external validation can also be very important in bringing decisions forward and that the DHHS Office on Women's Health has provided academic health centers with this validation by designating them as National Centers of Excellence. Other examples of external validation include NIH funding and support from enlightened donors or business partners. Public demand, including from advocacy groups, voters, and local politicians, is another force that can be used to affect a new vision. And finally, she described grassroots leadership as those within and outside the institutions who from their hearts would like to affect this change on a daily basis.

Dr. Milliken stated that in order to be the most successful in changing the paradigm, it is important to have all four of these catalysts, because each provides a different kind of motivation. She concluded by stating that to sustain this new paradigm it will be necessary to invest long-term, measure success, and support diverse leadership.

Following Dr. Milliken's presentation, a question and answer session was moderated by Dr. Margaret McLaughlin.

PLENARY B

This plenary session included two presentations. **Clyde H. Evans**, Ph.D., Vice President of the Association of Academic Health Centers, addressed "The Future of Academic Health Centers: The Role of Women's Health." **Nancy Fugate Woods**, Ph.D., Dean of the School of Nursing of the University of Washington, Seattle, made a presentation entitled, "Organizational Change in the Centers of Excellence in Women's Health: What Now and What Next?"

The Future of Academic Health Centers: The Role of Women's Health

Dr. Evans stated that the Association of Academic Health Centers (AHC) represents membership nationwide concerned with health professionals' education, biomedical and other health related research, patient care, and community services. The AHC analyzes ongoing issues, such as the importance of multi-professional education and multi-professional teams of care. It also addresses issues of immediate concern, such as the impact of managed care on the quality of care that patients receive and on the morale of health professionals, and the impact of Federal policies such as the Balanced Budget Act of 1997 on the viability of academic health centers. In addition, the AHC also attempts to identify future trends.

Dr. Evans stated that academic health centers are under tremendous stress due to the changing health care environment which is producing radical changes. He noted that three years ago the AHC undertook a study on the impact of these changes—how they are affecting the academic vision of education and research, as well as organization governance and financing issues. The study also sought to identify the range of models and strategies that will characterize successful centers. The study's findings include the following:

- As complexity and competition increase, especially in a cost-conscious environment, strategy and focus become more important.
- Clinical restructuring offers a chance to accomplish reorganization across the entire academic health center.
- Societal forces, both from the government and from the marketplace, are making accountability more important than ever before.

- Patient-centered care will require the use of all health professionals, not just physicians.
- Each academic health center must have a research mission.
- Institutions must find a way to preserve individual initiative and entrepreneurship while recognizing and rewarding institutional success.
- Faculty must work across boundaries.

All of these changes inevitably involve deep cultural shifts that will change the roles of leaders at every level and will have a tremendous impact on faculty. Dr. Evans noted the similarities between the characteristics of future academic health centers and those of the CoEs. There is an overlap in goals and on how to achieve them.

He shared his view of women's health, stating that women's health cannot be seen as women's diseases. The focus must be on the care of a person, not just the treatment of a biological entity; on not just acute but also chronic care. There is a need to shift from an emphasis from disease and treatment to a focus on sustaining and optimizing health—an interdisciplinary approach that focuses on the holistic picture of women's health. He also noted the changing nature of the patient-doctor relationship, stating that the doctor is no longer the sole possessor and dispenser of knowledge. Doctors must listen to patients and be sensitive to their needs.

Dr. Evans stated that although women make up a little more than half of the population, they constitute over two-thirds of the buyers and users of health care services. Women are responsible for 66 percent of dollars spent on health care and 75 percent of health care decisions. Sixty-five percent of all surgeries are done on women, and 75 percent of nursing home patients are women. Women are also hospitalized 15 percent more than men. They spend $121 billion per year on health care, with only $41 billion being spent on reproductive health services. Women are also one-third more likely to seek alternative care. And most of these expenses are paid for out-of-pocket. These figures suggest that women's health can be profitable.

Dr. Evans stated that the CoEs can show the way and point the direction for other academic health centers. Success breeds imitators. If CoEs are successful, they can serve as catalysts for deeper changes within other

academic health centers. Women's health can serve as the vehicle for moving academic health centers in a different direction.

Dr. Evans concluded by stating that the AHC seeks to identify best practices and disseminate findings to all of its members. Ultimately, the AHC would like all academic health centers to be Centers of Excellence.

Organizational Change in the Centers of Excellence in Women's Health: What Now and What Next?

Nancy Woods, Ph.D., Dean, School of Nursing, University of Washington, Seattle, stated that since the CoE program was initiated, there has been an important national effort to transform the delivery of health services to women with an emphasis on prevention and the early detection of disease. She noted that the CoEs are primarily concerned with *transformative change*. This change should result in new models of health services delivery grounded in the redefinition of women's health, a change in frameworks for thinking about women and their health, and new methods for service delivery. If this transformation is successful, CoEs will be able to create a new approach to health care that can have profound effects on the health of women in this country.

Dr. Woods stated that the purpose of her presentation was to consider the nature of change as it relates to the future of the CoEs, examine why change efforts sometimes fail in organizations, consider how CoEs might counter these problems, and propose strategies for second-order change. She noted that significant progress has been made in the past 30 years, a progress that has rapidly changed the face of the care given to women. Women's health has been redefined as well being, as more than reproductive health. The goals of women's health are now to attain, regain, and retain health, she said. Rather than gynecology, women's health is now seen as "gyn ecology," or the study of women's health and ecology. Women's health has been transformed from a fragmented model to a synthesis of knowledge—an integrated, holistic view.

This redefinition of women's health calls for a readjustment of the conceptual frameworks used to think about women. It places women at the center of the inquiry. It calls for new frameworks of thinking about women and their health.

Dr. Woods distinguished between two types of change: first-order and second-order change. In first-order change, the tendency to seek equilibrium restores the system to its original state. The more things

change, the more they stay the same. With second-order change, on the other hand, the whole system changes. This type of change occurs at the next level of the system's organization. For example, for CoEs, a first-order change would be the integration of new health care disciplines. A second-order change would be the implementation of a new model for the delivery of health care services, training, and education.

Dr. Woods noted that CoEs have both overt and covert missions. Their overt mission is what is made public—improving the health of women across the life span—while their covert missions include things such as generating income, providing teaching and learning opportunities, and recruiting research participants.

There are many forces that resist transformative change at the CoEs. They include:

- Fear of a loss of resources and of changes in power and status.
- Fatigue or lack of energy.
- Failure to establish a sense of urgency and to stress why women's health is valuable and how the CoE can serve as a model.
- Failure to create a powerful guiding coalition that includes senior faculty in leadership positions as possible advisory board members.
- Failure to communicate a vision of what change will produce and to remove obstacles to the vision, such as organizational structures and restrictive job descriptions.
- Failure to systematically plan for and create short-term successes.
- Declaring success too soon.

In order for organizational changes to occur, 5 to 10 years may be needed, and the changes must be anchored in the organization's culture.

Dr. Woods stressed the need to implement initiatives to sustain the CoEs over time. It is important to make the link between the clinical care and research missions explicit and valuable to the organization. The link between outreach efforts and the research mission should also be made apparent and of value to investigators and to the community. The clinical care and teaching missions must be aligned across the health professions programs. It is also critical to make the CoE visible to the community and to key local coalitions and responsive to their concerns. In addition, it is

necessary to evaluate the effectiveness of the health care delivered by the CoEs and publicize the results of the evaluation broadly.

In closing, Dr. Woods stated that the Centers of Excellence are not a "trendy marketing gimmick," but truly *transformative* institutions.

LUNCHEON ADDRESS

On Tuesday, November 2, **Former Congresswoman Pat Schroeder**, J.D., President and Chief Executive Officer of the Association of American Publishers, presented a luncheon address. Mrs. Schroeder opened by stating her joy that the Centers of Excellence have become a reality. She acknowledged the many advances that have been made in women's health, exclaiming, "what a great way to end this century!" Mrs. Schroeder noted the 30 year increase in the average life expectancy for women that has occurred since the beginning of the century, and stressed the need to continue the momentum in women's health.

Mrs. Schroeder stated that our culture tells women that if they stand up for their rights, there is something wrong with them—they are too self-absorbed. It is therefore very difficult for women to lobby for their own rights as they do for other causes.

She mentioned some of the women's health issues with which she has been involved. They include domestic violence, safety in the home, guns and their impact on women, reproductive issues, and safe motherhood. She noted that the U.S. still has statistics that indicate poor outcomes regarding motherhood and lacks standardized statistics among states, noting that these issues must be addressed.

Mrs. Schroeder acknowledged that women are under much stress. Although they can now pursue many occupations outside of the home, they are still responsible for the domestic activities they were doing before. She said it is necessary to consider ways to help women manage this stress.

Mrs. Schroeder traced some of the history of U.S. legislation on women's health, particularly during her tenure in Congress. She noted that initially there was no research on women's health and that it was difficult to convince Congress to address this issue. Women's health was repressed. Women were even ashamed of revealing that they or their family members had breast cancer. Mrs. Schroeder noted that funding for women's health is still often viewed by Congress as a gift. When women pay taxes; however, it is not considered a gift, she noted. The former Congresswoman stated that Congress often has the attitude: "women's health, we did that last year." Congress needs to understand that women's health cannot be addressed by a one-time effort. She mentioned that this year Congress tried to cut funding for the Education Equivalence Office in

the U.S. Department of Education and refused to sign the Convention on the Elimination of All Forms of Discrimination Against Women, an international treaty on the status of women that has been approved by 160 countries.

Mrs. Schroeder also described the difficulties she faced in Congress when attempting to have breast and cervical cancer screening covered under Medicare. She stated that Congressmen do not think about women's issues—they do not hear about them or know about them. And, as there never is enough money to fund everything, she said, they tend to fund what they fear. Mrs. Schroeder noted that women still have not reached a critical mass in politics.

Mrs. Schroeder stated that the work to address women's health is not over and encouraged attendees to "keep on pushing." She reiterated that women pay taxes, and therefore women's health legislation cannot be seen as a gift. She noted that the goal was that by the end of the century, the level of scientific knowledge regarding women's health would have reached the same level as that of men's health. "We're not going to make that," she said, "but we are going to get close." She encouraged women to vote, to become involved.

WORKSHOPS

Clinical Care

The Clinical Care track consisted of 5 workshops addressing issues related to the successful marketing, financing, and delivery of comprehensive women's health services. The overriding theme of the Clinical Care track was that comprehensive, lifetime women's health care is at the core of the CoE philosophy and mission. Major challenges included patient access, financial support, and obtaining buy-in in putting forth this model of women's health care. The clinical care track also included sessions on marketing women's health care, presenting the financial value of women's health programs to the supporting institution, and an interdisciplinary teaching model developed within an academic clinical setting.

In **"Creating Women's Health Care Centers: Diverse Models With Common Goals,"** *Nancy Milliken*, M.D., director of the CoE at the University of California, San Francisco, offered an overview of the evolution of women's health care. Initially, men and women were assumed to have the same health care needs and received the same treatment. Later, women's services focused on reproductive health; this marked the beginning of patient participation. Today, the current debate is between the "one-stop shopping" model for women's health services, which is a centralized system, and a "center without walls" which is community-based and flexible. Both models expanded from a focus on the reproductive years into a lifetime definition of women's health, and increased emphasis on prevention, multi-disciplinary collaboration, and patient-centered care. Three CoEs then described their varying models of comprehensive clinical care for women.

Michelle Battistini, M.D., director of Penn Health for Women at the University of Pennsylvania CoE, described an example of the "one-stop shopping" model. It evolved from two motivating factors: the need for a marketing strategy to capture the women's health market and bring in more money to the university; and a commitment to leadership in women's health care. Penn's program for comprehensive health care for women of all ages includes characteristics key to other CoE models:

- Multidisciplinary team
- Focus on disease prevention and healthy lifestyle promotion

- Services designed around the application of primary, secondary, and tertiary preventive strategies
- Delivery of medical care that is patient focused, user friendly, and addresses issues of access and convenience

The program consists of multi-specialty satellite sites that serve as leaders in women's health within the community through the provision of high quality, comprehensive services. In addition to medical services, each site offers on-site patient education programs. Penn also offers educational programs in the community (such as a seminar series that take place at local bookstores) a speaker's bureau, and an indigent community program.

The project receives funding from institutional, departmental, benefactor, grant, and other contract sources. It is not a break-even operation when assessed in terms of direct revenue. The financial value rests on diligent tracking of spin-off (downstream) revenue.

Laurel Dawson, M.D., Clinical Director, described the University of California, San Francisco (UCSF) CoE model as the opposite of Penn. UCSF's network of women's health centers combines academic-based and community-based practices focusing on ob/gyn and internal medicine. The network has evolved to promote more comprehensive women's health care. USCF has five locations that provide a combination of primary care services. Not all sites have exactly the same services, so that each can be responsive to specific patient need issues in its location. Because the network is a combination of community and academic sites, the model requires strong administrative support.

The five centers receive 30,000 visits per year. They have linkages into specialized secondary and tertiary care services, which are part of UCSF. All women's health facilities have standardized features, such as patient education materials, even though they are administered separately. Services include a breast care center, HIV care for women and children, infertility treatment, a continence center, menopause consultative service, cardiovascular service, a mental health clinic, and a disordered eating program.

Deborah Linhart, from the Magee Womens Hospital of the University of Pittsburgh Medical Center Health System, described the CoE clinical program as an evolving hybrid of the first two models. Magee is one of the few women's and children's hospitals in the country. It has a main campus and 12 satellites. The basic model embodies nine main concepts:

quality care, information, research, respect, empowerment, access, integrated comprehensive care, cost-effectiveness, and advocacy. It deals as much with the processes of care as the outcomes of care.

Magee initially opened breast centers, which have been converted to "Womancare Centers." As Magee opened more clinics, it became decentralized. It evolved from a hospital to a system that offers care wherever the patient is, including women's shelters, grocery stores, and the workplace. Magee sponsors six Womancare Centers in Pittsburgh, each one providing different services depending on patient needs, and also has a program in Eastern Europe called Womancare International. Community-hospital partnerships and neighborhood health center that are integrated with community resources are hallmarks of Magee's system.

In conclusion, Ms. Linhart stated that women's health must be a commitment, not a marketing strategy.

In **"Reaching Out: New Frontiers in Telehealth,"** *Rebecca Crowley*, M.D., from the University of Pittsburgh's Center for Biomedical Informatics, which is part of the Magee CoE, demonstrated telepathology, the practice of pathology at a distance, specifically, viewing pathology slides on a video monitor. Through telepathology, pathologists can act as information managers for surgical pathology (e.g., biopsies), autopsy pathology, clinical laboratories, and molecular diagnostics. There are several variations of telepathology:

- Static, in which certain areas of slides are projected on the video monitor, vs. dynamic-robotic, in which the pathologist can manipulate the microscope with a remote "joy stick" to view different areas of a slide;
- Diagnostic use vs. clinical consultation between pathologists and other clinicians; and
- Primary diagnosis vs. consultation with a primary pathologist in a remote location.

The University of Pittsburgh is looking into Web-based virtual telepathology, which can reproduce an entire slide at varying powers.

Dr. Crowley also discussed telereporting, which she described as the sum of activities leading to an electronically-based report. A single report can be tailored to different audiences, e.g., for a primary care physician, for the patient, and for the pathologist.

Beverly Jones, M.D., from the Wake Forest University School of Medicine CoE, discussed the use of telepsychiatry, particularly in terms of long-term care of geriatric women's mental health. Geriatric mental health is an issue among women because Alzheimer's occurs more frequently in women (who generally have a longer lifespan than men), depression is more common in women, and the caretakers of dementia patients are mostly women. Dr. Jones found telepsychiatry helpful among patients who do not like hospital settings or talking to a psychiatrist in person. A recent study found that most people accept teleconsultation. However, people are divided about whether they prefer face-to-face or telepsychiatry on a continuing basis, given the choice. Rural patients are more satisfied with teleconsultation than urban patients, and females are less supportive of it than males. Dr. Jones then demonstrated a teleconsultation with a rural hospital.

Michelle Gailiun, M.D., from the Ohio State University Medical Center (OSUMC) CoE, discussed the use of telemedicine in prisons. OSUMC has over 30 sites in its prison telemedicine network. Rather than transporting a prisoner to a health care facility or having a physician travel to the prison, prison medical staff (usually nurses) conduct the physical assessment on site, while the doctor watches at a remote site. One of the tools that can be used in telemedicine is an electronic stethoscope that can be heard at the remote site.

There is a high utilization of health services among women in corrections, with a resulting cost 40 percent higher than for male inmates, so telehealth is important. OSUMC's telehealth network has cut travel costs, virtually eliminated patient backlog, integrated telemedicine as a way to do business, and improved safety and security. OSUMC has learned that technology works, patients like it, and doctors like it—once they have tried it.

"Branding and Marketing of Women's Health Care" discussed the process of branding women's health services to increase market share and strengthen consumer preference. The four components of the session addressed: the branding process as it applies to women's health; differential marketing; strategies to market academic women's health centers; and community networking as a marketing strategy.

"Financial Assessment: Proving Your Value to the Institution" offered practical suggestions for measuring and presenting the financial value of women's health programs to participants' institutions. The same characteristics that make the CoE's women's health programs unique and deserving of national recognition are those that make the CoE programs

most vulnerable in the academic setting: a focus on prevention and primary care, a requirement for cross-departmental collaboration, and a commitment to improving the health status of underserved women in the community. This inherent conflict requires that the leaders of women's health programs be even more scrupulous in their financial management and program evaluation.

"Women's Health in a Primary Care Setting: An Interdisciplinary Approach in an Urban and Suburban Setting" provided an overview of the Tulane/Xavier and Yale CoE clinical models. The initial Tulane/Xavier clinical model offered women access to comprehensive medical services but did not offer adequate services to indigent women. The Hutchinson Clinic's Women's Health Clinic of the Medical Center of Louisiana offers access to comprehensive medical care for this population. The Yale CoE clinical model offers women access to an array of services provided by diverse practitioners, as well as to the full range of comprehensive medical and support services available in the Yale Primary Care Center and throughout the Medical Center.

Research

The Research track consisted of six workshops addressing issues related to future directions and continued support for women's health research. Main topics included selling multidisciplinary research to researchers, academic institutions, and funding organizations; and ensuring adequate representation of diverse consumer populations in women's health research. The research track also included sessions on measuring patient satisfaction, increasing the participation of underserved women in clinical research, and the use of databases as a method to assess the health status of women and as a tool for research.

In **"Multidisciplinary Research: What, Why, and How,"** *Carolyn Mazure*, Ph.D., from the Yale University CoE, defined multidisciplinary women's health research as an investigational approach that fosters research within and across multiple disciplines for purposes of generating a comprehensive and integrated knowledge base on the health of women. The rationale for multidisciplinary research is that every discipline needs to increase its knowledge base on the care of women, who have been traditionally omitted from research. Integration is necessary because women's health status can be affected by multiple variables that fall within different disciplines.

Margaret McLaughlin, Ph.D., from the CoE at University of Pittsburgh, addressed one aspect of "how:" how to promote multidisciplinary research and obtain fiscal support.

- The investment of time, rather than money, can be very effective. For example, having a human subjects committee also look at how to optimize patient recruitment adds value to the committee.
- Small institutional grants can be used to demonstrate multi-disciplinary activity.
- To obtain Federal funding, it is necessary to understand how the system works and how to craft a well-written proposal that speaks to the system.
- To obtain foundation support, it is necessary to understand the power of the institutional board, and understand how the institution's development office works.

David Frid, M.D., from the Ohio State University (OSU) CoE, looked at how to attract researchers into multi-disciplinary research. Since many researchers do not see the benefits of this kind of research, it is important to "sell" such benefits as opportunities for unique cross-discipline collaborations, and expanded opportunities to pursue grants and seek answers to research questions.

Methods that the OSU CoE uses to attract multidisciplinary researchers include a research forum, a researcher directory, a listserv of women's health announcements (including funding opportunities, events, and conferences), focus/interest groups, and a listing of opportunities to participate in research.

Valerie Petit Wilson, Ph.D., from the CoE at Tulane/Xavier University, discussed how to coordinate across institutions. Tulane and Xavier have coordination at key levels, most notably a relationship of trust and partnership between the presidents of the two universities. They also have programs and centers that are cross-institutional, allowing for sharing of information among students and faculty.

It is challenging to learn where resources lie and who the contributors are. To successfully coordinate, it is important to bring contributors together in both locations and ensure that there is benefit in it for everyone.

In the **"Federal Women's Programs: Been There; Done That; Now What?"** session, *Judith LaRosa*, Ph.D., former director of the Tulane/Xavier

CoE and currently with the State University of New York Health Science Center at Brooklyn, introduced the following issues for consideration:

- What remains to be done?
- Where should Federal agencies direct their resources?
- How should we assure that equity is finally and firmly embedded in research?

Dr. LaRosa described a bill currently under consideration in Congress that would rename the National Institute of Child Health and Human Development (NICHD) as the National Institute of Women's and Children's Health and Human Development (NIWCHD). Dr. LaRosa believes that such a change would encourage a focus on women's reproductive health rather than on women's health across the life span, in contradiction to the current efforts of the National Centers of Excellence in Women's Health.

Marcy Gross, from the Agency for Healthcare Research and Quality (AHRQ), described AHRQ's research interests as broad and consistent over time, outcomes; quality; and cost, use and access. Future research directions include aging, disparities in health care access and outcomes, partnering with NIH, and domestic violence.

Yvonne Green, from the Centers for Disease Control and Prevention (CDC), identified CDC's current areas of research as food safety, emerging infectious diseases, viral terrorism, occupational safety and health, and breast and cervical cancer. Future directions in women's health research include cardiovascular disease, smoking, reproductive health, health disparities, violence against women, and working with communities.

Kenneth Bertram, M.D., Ph.D., from the U.S. Army Medical Corps, discussed Congressionally directed medical research programs which function on special appropriations for specific disease topics mandated by Congress. These programs go through peer and programmatic review and are strongly influenced by consumer advocates. Current Department of Defense (DOD) research programs focus on breast cancer and ovarian cancer. The DOD does not have a policy regarding research in women's health; future directions will be determined based on the research needs of the community, increased communication and coordination with other Federal agencies, and increased consumer participation in determining funding decisions.

Jonca Bull, M.D., from the Food and Drug Administration (FDA), stated that the FDA's mission is to promote and protect public health, primarily through pre-market approval of drugs, biologics, and some medical devices. The FDA's Women's Health Office ensures that the FDA remains gender sensitive, promotes an integrative and interactive approach, and forms partnerships with government and non-government organizations. In 1977 the FDA initiated a policy that excluded women of reproductive potential from drug studies. In 1993, this policy was reversed and gender guidelines were established. The FDA is fully represented on the OWH Gender Effects Science Council. A key women's health issue now under consideration is the use of drugs in pregnancy.

Loretta Finegan, M.D., described the three-part mandate of the NIH's Office of Research on Women's Health (ORWH): to identify and fill in gaps in knowledge; to ensure and monitor appropriate participation of women and minorities in clinical trials; and to educate women via dissemination of sound research. Its future goals include continuing to carry out this three-part mission, and to recruit women into biomedical careers.

In **"Funding for Women's Health Research: Foundation and Industry,"** *Catherine Allen*, Ph.D., from the University of Wisconsin - Madison CoE, explained that funding for women's health research has increased within the last 10 years. The traditional sources of funding are pharmaceutical companies and associations that target specific diseases. New foundation funding includes investigator-initiated research, foundation-specific initiatives, academic training, and program development. New industry funding includes investigator-initiated research, academic training, and partnering with institutions.

Jerome Strauss, M.D., Ph.D., director of the CoE at the University of Pennsylvania, discussed industry-sponsored research and the rationale for building a clinical trials enterprise in an academic setting:

- To increase the repertoire of drugs and devices for women's health care;
- To increase dialogue between academic health centers and industry;
- To provide faculty with early experience with promising new agents / devices;
- To take advantage of an important source of revenue; and
- To contribute to academic productivity.

Dr. Strauss described the structure and function of the University of Pennsylvania's women's health clinical trials unit, and the issues that can arise, such as internal review board approval, possible conflicts of interest, and publication rights.

Gayla VandenBosche, M.A., from Magee Womens Hospital, described Magee Womens Research Institute, which obtains three percent of its annual $7 million operating budget from industry and four percent from foundations (the remainder coming from Federal grants and subcontracts). Although the amount is relatively small, this funding is important for a number of reasons:

- It funds young researchers who later bring in more money for studies.
- Industry money is more flexible than Federal money and provides a safety net when Federal money dries up temporarily.
- Magee receives a lot of equipment from industry.

Shellie Ellis, M.A., from the CoE at Wake Forest University (WFU), described the institutional infrastructure that supports non-public research funding at WFU. The Office of Research has a tracking system for funding and publishes *Pursuit*, a newsletter that includes notification of funding opportunities. It also has a technology transfer program and a "community of science" database, and supports a culture of collaboration through dissemination of funding information. The Office of Development deals with major gifts and corporate and foundation initiatives. The WFU CoE has a research program support unit that supports pilot and new investigator programs, facilitates multidisciplinary research groups, and educates the community about participating in health research.

In response to a question about forming a central CoE consortium that industry could approach, participants learned that a CoE consortium was formalized last year and that a working group of CoE research directors are working on this project, particularly in reference to soliciting and allocating federal research funds.

"Measuring Patient Satisfaction" was a panel presentation that discussed key research issues in assessing patient satisfaction, its importance as an indicator of quality of care, and progress toward developing a women's health patient satisfaction instrument.

"Increasing the Participation of Underserved Women in Clinical Research" addressed these key points: definition of "underserved populations;" data on low representation of women of color and other

women's groups historically neglected in clinical research; methods for recruiting underserved populations in clinical research; and description of the barriers to recruitment and retention of underserved populations, including methods for how barriers might be overcome. The session presented the results of a research study known as the Barriers Study, which was performed at the University of Michigan in 1998.

"Databases: A Method to Assess the Health Status of Women and a Tool for Research" introduced participants to a list of available databases and how they can be used for research and to determine the health status of a population of women. The session aimed to provide participants with a basis with which to judge the accuracy, appropriateness, and usefulness of a database, and to provide an example of how a database can be used as a research tool.

Professional Education

The Professional Education track consisted of five workshops addressing the importance of and strategies for integrating a variety of women's health issues into all levels of medical training.

The goal of the session **"Utilizing Computers to Enhance Education"** was to highlight strategies and modalities used by different CoEs in integrating women's health into medical school curricula through computer-based methods. The integration of women's health into the medical curriculum has been a central focus of the CoEs. As part of this process, the CoEs at the University of Washington, Seattle; University of Pennsylvania; Wake Forest University; and MCP Hahnemann have developed on-line women's health teaching programs and resources, providing an excellent opportunity for students to gain knowledge outside of the traditional methods.

During this session, representatives from the four CoEs presented information on how they have used computers to integrate women's health into the curriculum. These include online case-based learning modules, a virtual curriculum, a "Web Station" for a new "symptom-based module curriculum," and the use of Internet resources such as Medline references and Web sites to enhance learning. The CoE at the University of Washington has developed case-based modules in women's health for students to use on their own and for teachers to use in small group settings. These modules progress from basic information important for all students to more specialty-oriented questions to enhance learning. The CoE at the University of Pennsylvania has implemented the Virtual

Curriculum 2000, a new integrated modular curriculum that is accessible to students at any time from any computer. The Women's Health and Reproduction block of this curriculum is an integrated module of lectures and cases on women's health issues and is often used by students during their Organ System block, obstetrics / gynecology / pediatric rotation, and other clinical clerkships. The "Web Station" developed by MCP Hahnemann includes women's health learning objectives and lecture notes, and directs students to relevant Web sites pertaining to curricular topics. Each of the CoE programs presented had innovative methods of using computers to educate medical students about women's health issues.

The **"Strategies for Integrating Women's Health in the Undergraduate Curriculum"** session was presented by *Richard Derman*, M.D., from the CoE at the University of Illinois at Chicago, and *Barbara Schindler* M.D., from the CoE at the MCP Hahnemann School of Medicine. The session was designed to provide participants with curriculum models and to further discuss strategies for planning and integrating women's health educational objectives into the undergraduate medical curriculum. Curricular changes require significant strategic planning. In order to successfully integrate women's health into the curriculum, programs need to identify key faculty, administrative, and committee support. It is also important to define their roles in curriculum management and revision, to ensure active participation. In addition, student trainees play a significant role in the planning process and during implementation. Their input is critical in successfully integrating women's health into the curriculum.

Dr. Derman and Dr. Schindler discussed three models for integrating women's health into the undergraduate medical curriculum. After these models were presented, participants were encouraged to discuss their experiences in order to identify other programs, gain further knowledge, and learn from others successes and mistakes.

The goal of the session **"Models for Incorporating Women's Health into Post-Graduate Education"** was to discuss methods of integrating women's health into existing training programs and their resources, discuss methods of funding women's health curricula, and to share resource materials from other institutions. There is currently limited funding available to incorporate women's health into the education of residents. Therefore, creative strategies are needed to accomplish this task.

During this session, representatives from the CoEs at the Indiana University School of Medicine, the Medical College of Pennsylvania

Hospital, the VA Boston Healthcare System / Boston University, and the Yale University School of Medicine discussed the ways in which their CoE programs have integrated women's health into post-graduate education. *Janet Henrich,* M.D., from Yale University, discussed the importance of collaboration of faculty along with departmental support in successfully incorporating women's health. *Ann Zerr,* M.D., from Indiana University, and *Sandra Levison,* M.D., from the Medical College of Pennsylvania Hospital, presented techniques for introducing women's health into the curriculum such as identifying interested parties (Ob / Gyn, Internal, and Family Medicine), identifying resources for clinical training experience, independent studies in women's health, conferences, and requiring core competencies in women's health. Dr. Levison also talked about a multi-pronged approach which views the teaching of women's health as the responsibility of all trainees.

Drs. Levison, Donoghue, and Tunkel, from MCP Hahnemann University, have developed a curriculum in women's health for the internal medicine residency. Other methods of introducing women's health are through vehicles such as medical grand rounds, the use of the "what if prompt," the use of Objective Structured Clinical Examinations (OSCEs) and standarized patients and the rotation of residents through the Center for Women's Health. In addition, *Susan Frayne,* M.D., from the VA Boston Healthcare System / Boston University, and Dr. Janet Henrich addressed some of the difficulties they have encountered, such as the collaboration of faculty and obtaining financial support and what they have learned to help other programs develop strategies to overcome these obstacles. The Yale CoE has received in-kind support from the Yale School of Medicine and the Yale New Haven Hospital and supplemental funding through small educational grants.

The session **"Funding for Advanced Training in Women's Health,"** featured presenters from the CoE at the University of Wisconsin - Madison, the National Institute on Aging, the National Institute of Nursing Research, the National Institute of Child Health and Human Development, and the Department of Veterans Affairs. The session focused on providing participants with information about grants and scholarships available to support academic training in women's health research and to address some of the challenges and solutions related to developing careers in academic medicine.

Women remain underrepresented in the leadership of academic medicine. This lack of progress of women into leadership positions involves several issues including, climate of workplace, gender discrimination, and a lack

of female mentors. Women's health research offers an array of areas for scientific inquiry and an opportunity to develop women leaders in academic medicine. In recent years there has been some progress as the number of women students and professionals has increased. There has been increasing funding for women's health research at each level of the career ladder, such as women's health fellowships, postdoctoral research fellowships, junior faculty transition support, and senior faculty awards.

Representatives from the Department of Veterans Affairs (VA), the National Institute on Aging (NIA), the National Institute of Nursing Research (NINR), and the National Institute of Child Health and Human Development (NICHHD) presented information on federal funding opportunities available from each of their agencies. The NIA offers funding for research on the aging process, related diseases, and special needs and problems of the aging. Some of the research specific to women's health includes Alzheimer's disease, osteoporosis, menopause, and hormone replacement therapy. Dr. J. Taylor Harden, from the NIA, also offered information on how, when, and for which funding opportunities to apply.

Eliza Wolff, Ph.D., from the Department of Veterans Affairs, presented information on the VA fellowship program aimed at preparing physicians for academic careers in health issues pertaining to women veterans. *Carole Hudgings*, Ph.D., from the NINR also discussed the types of research NINR supports. Some of the major themes of NINR research are: gender differences and responses to pain, exercise (e.g., benefits to older sedentary women, health promotion and how it effects women), and caregiving issues (e.g., caregivers of older parents are often women). Lastly, *Donna Vogel*, M.D., Ph.D., from NICHHD, discussed the types of research the agency funds and the mechanisms of support for these projects. Some of these projects include research on contraception, contraceptive behavior, mammography, and family structure. Overall, these government agencies offer many funding mechanisms to support research, career development, and training.

The session **"'If you do not know me, how can you treat me?': Cultural Competency in the Curriculum of Medical Schools and Diversity Among Women of Color Related to Their Health Needs"** focused on facilitating understanding of the importance of including the health of women of color in the curricula of medical schools. *America Facundo*, Ph.D., from the CoE at the University of Puerto Rico School of Medicine, *Ana Nunez*, Ph.D., from the CoE at MCP Hahnemann School of Medicine at Drexel University, *Maria Soto-Greene*, M.D., from the New Jersey

Medical School at the University of Medicine and Dentistry of New Jersey, and *Martha Medrano*, M.D., from the Hispanic Center of Excellence at the University of Texas Health Science Center at San Antonio, also addressed the various complex issues associated with developing culturally competent women's health curricula. Presenters discussed the difficulty of being culturally competent and sensitive across diverse communities. Different cultures have special issues of which medical students and physicians need to be aware to effectively care for patients. Another important discussion topic was the issue of cultural identity for women of color. It is important for physicians to understand that many women of color in America feel that they are caught between two cultures, not fitting in with either. Another issue of importance in developing a curriculum is teaching students to respect and value patient input and developing better communication skills. Medical students should learn how to communicate effectively with women of color and to listen to their concerns, which will help to improve the health care provided. The session presenters also stressed the importance of acknowledging that many differences do exist and addressing the health care providers' cultural values, as well as trying to understand the patient's cultural values.

The session also addressed ways of increasing medical students' awareness of these difficult issues. The use of art and literature to enable students to better understand, listen to, and connect with women patients of color was discussed. Lastly, session presenters highlighted the need for experiential learning in culturally diverse settings for all medical students.

Leadership

The Leadership track consisted of six workshops addressing issues related to enhancing the leadership of women in academic medicine as well as fostering their recruitment, retention, and promotion. Major themes were mentoring and strategies that can be used to advance women.

"Leadership Issues for Faculty Women of Color" focused on issues relevant to the promotion and advancement of minority faculty women in the academic health sciences. *Emily Wong*, Ph.D., from the CoE at the University of Washington, Seattle, opened the workshop by providing an overview of current conditions. National statistics show that minorities and women are underrepresented in medical schools and allied health professions, with little change over the past 20 years; that women remain underrepresented in higher faculty ranks; and that minority faculty (both women and men) predominantly populate lower ranks. A critical factor in facilitating leadership plans is support from the institution's leadership;

but there is a wide range of institutional support that is needed. Barriers to progress include not only internal influences such as an entrenched hierarchy and time demands, but also external threats such as market forces and anti-affirmative action legislation. Among conclusions were that: minority women faculty have little visibility and few advocates; data are lacking at both institutional and national levels; programs targeting either women or minorities may fail to address relevant issues; minorities and women suffer from lack of mentoring and role models; and minorities face racial as well as economic barriers. Further research is key; institutional support for recruitment and retention is essential; and measurements for progress need to be in place.

The workshop continued with four small group sessions facilitated by *Dr. Wong*, *JudyAnn Bigby*, M.D., from the CoE at Harvard; *Alice Dan*, Ph.D., from the CoE at the University of Illinois at Chicago; and *Myra Kleinpeter*, M.D., from the CoE at Tulane/Xavier University of Louisiana. Issues addressed by the facilitators in their summaries included the importance of mentoring and the qualifications of a mentor, institutional culture and the need for critical mass to strengthen the identity and experience of minorities and women, the need for specific action plans and timelines to effect change, and the need to develop a database/roster of minority and women faculty in medicine. Discussion also focused on the "pipeline" or track leading to tenure and administrative positions. Facilitators referred to the socioeconomic and technological gaps that can prevent women and minorities from entering the pipeline, as well as to the lack of role models in many communities. They stressed that differences—including racial and ethnic differences—should be seen as neutral in academic medicine.

"Computerized Mentoring: Using Information Technology To Advance Women's Careers" addressed novel approaches to mentoring that use information technology and provided practical examples. *Merle Waxman*, M.A., Academic Dean at the Yale University School of Medicine CoE, described the e-mail mentoring program for undergraduate women which is now in its second year. In order to set up the program, notes were sent to all female medical faculty explaining the need to encourage young women to pursue careers in science and medicine and the lack of both student and faculty time. Faculty were asked to be volunteer e-mail mentors. The matching process was arduous in the first year and about 20 matches were made; interactions were positive. Many mentors have signed up for a second year.

Rosalyn Richman, M.A., from the CoE a MCP Hahnemann University, discussed e-mentoring through the University's National Center of

Leadership in Academic Medicine (COL)—a program started in 1998 by the Office on Women's Health, DHHS, to support junior women-and men-faculty—Web site and the Executive Leadership in Academic Medicine (ELAM) program's listservs. Through e-mentoring, faculty are able to access a village of mentors, using such technology as e-mail, bulletin boards, chat rooms, and video conferencing. E-mentoring contact between parties is both synchronous and asynchronous; and encourages interdepartmental and interdisciplinary mentoring. The University's COL e-mentoring Web site is open to all faculty and, therefore, also used by the CoE. Application forms and other information on the ELAM program are included on the ELAM site at (www.mcphu.edu/institutes/iwh/elam/nomination.html).

Jayne Thorson, Ph.D., from the CoE at the University of Michigan Medical School, described how e-mentoring was provided through a faculty affairs Web site that makes available a wide range of information as well as advice and counseling for career advancement. From this site, the following information on the medical school is available: departments, programs, faculty, faculty resources, faculty funds and partnerships, faculty handbook, executive and advisory committee membership, announcements on awards and seminars, guidelines for curriculum vita preparation (developed through the CoE), evaluation forms, and e-mail addresses.

"Effective Use of the Institutional Report Card To Advance Women," which was moderated by *Glenda Donoghue*, M.D., from the CoE at MCP Hahnemann University, looked at the strategic use of institutional benchmarking data—that is, an institutional report card—to enhance women's careers and leadership, improve the climate, and increase retention of both women and men. Other names for the data sets include gender climate assessments, perceptions of gender fairness in the environment, and surveys of gender-based obstacles.

Janet Bickel, from the Association of American Medical Colleges (AAMC), described how these data sets began to be used about 10 years ago. One of the first instruments to gather benchmarking data was developed and used by the Johns Hopkins University Department of Medicine. After a follow-up evaluation, results were published in *JAMA*. Although each institution needs its own data; examples can be useful. The AAMC Gender Equity Committee has collected benchmarking data and now has two-years of data that include, for example, reliable numbers for women on important committees and for women who were promoted. The data (for 120 schools) are to be published soon and should provide an invaluable

resource. AAMC may also be able to include gender breakdown of faculty information in its self-study database.

Sharon Foster, M.D., from the CoE at the University of Wisconsin - Madison, explained how the university adapted a gender climate survey for its institutional report card, adding questions concerning perceptions at the school, department, and division levels, as well as of career tracks. The first survey's results generated attention—committees were formed and individual departments developed goals. Progress reports are now prepared annually concerning, for example, recruitment, mentoring, networking, and promotion data. Responsive innovations have included First Friday networking meetings and hiring an ombudsperson.

Page Morahan, M.D., from the CoE at MCP Hahnemann University, noted that the first institutional report card consisted of data compiled in 1998 by the National Center of Leadership in Academic Medicine program documenting the effects of downsizing on women faculty both in leadership and junior ranks before, during, and after the financial problems at the University. The report card was derived fairly closely from the AAMC's methodology, and its data could be easily compared to the AAMC data—and revealed that women have not been disproportionately affected by the organizational stress and change.

"Strategies To Advance Women in Medicine: Leadership Plans" conveyed key principles for understanding and promoting leadership for women in medicine. *Janet Bickel*, from AAMC, first focused on why women's leadership in medicine was still an issue. One reason is devaluation: the need to break down stereotypical thinking persists. Another, as an MIT study has suggested, is that marginalization increases as women progress.

Workshop participants included *Merle Waxman,* M.A., from the CoE at Yale University; *Sharon Foster*, M.D., from the CoE at University of Wisconsin - Madison; *Margaret McLaughlin*, Ph.D., from the CoE at the University of Pittsburgh, *Sally Shumaker*, Ph.D., from the CoE at Wake Forest University; and *Eleanor Shore,* M.D., from the CoE at Harvard Medical School. Strategies to advance women presented by workshop participants included the following:

- Setting up AAMC seminars for women assistant professors to emphasize career building by developing research skills, and setting up seminars for women associates and full professors on making a job search, building capacity for change, and strategic career planning.

- Using funds to recruit outside and to add slots. This was a strategy at the Yale CoE when it became clear that there were not enough women in the pipeline for senior positions (since 1987 there had been 16 male recruits and one female recruit).
- Promoting networking through First Fridays and professional development through ELAM; setting up faculty equity and diversity committees; opening career tracks and providing change options; and training leaders through the MEDAL program.
- Encouraging a cultural shift concerning what constitutes success in academic medicine.
- Focusing on aspects of leadership by, for example, developing mentoring plans, supporting funding for awards and pilot grants for women faculty, and conducting gender-specific management programs.
- Using CoE funding as a catalyst for creative thinking about strategies in terms of low cost (collaboration, guest speakers, receptions, awards), medium cost (computer mentoring, Web site development), high cost (fellowship programs to protect time for activities to progress up the academic ladder), and highest cost (endowments, supplements).

In **"Novel Mentoring Approaches To Fit the New Millennium,"** *Page Morahan*, Ph.D., from the CoE at MCP Hahnemann University, first reviewed mentoring approaches by experts within and outside the Centers of Excellence. No one style of mentoring fits all, and each style must fit into the context of its school. In "godfather" or *traditional mentoring*, for example, a single sponsor promotes and protects. This is a type of mentoring in which it is harder for women to find women to serve as mentors. In "personal mosaic" or *multiple mentoring*, different people serve for an individual as a confidant, expert, political strategist, and cheerleader. This is the "it takes a village" idea. In network or *peer group mentoring*, each group member helps each other group member. An example is the Boston A-team, which was a group of women all of whom wanted to become CEOs and who helped each other to success. In *group mentoring*, a senior person meets with a group of junior individuals to advise and assist.

Practical examples of successful mentoring in academic medicine in the CoEs were then described by *Janet Bickel* from AAMC, *Paula Gregory*, Ph.D., from the CoE at Ohio State University, *Merle Waxman*, M.A., from the CoE at Yale University School of Medicine, and *Leslie Wright*, M.A., from the CoE at Boston University. These included using emeritus faculty

as mentors; routinely assigning faculty as mentors to incoming faculty; planning for short-term, time-limited (but still of benefit) one-on-one mentoring; and holding women-in-medical-science breakfasts and assigning table topics. Materials shared by participants included practical advice on where to find funding to support a mentoring program.

"Salary Equity Studies for Medical School Faculty" presented two examples (the CoEs at Yale University and the University of Michigan) of institutional approaches and methodologies for gender-based salary equity studies of medical school faculty. *Merle Waxman* explained that the Yale CoE, where data collection started in 1983, an annual report on faculty salaries includes salary, years at rank, and age according to degree (M.D., Ph.D., other). These data serve as a negotiating tool for current faculty and provide new faculty with a place to start. The percentage of women on the faculty is now 15.8 percent, double that when the data were first collected.

Jayne Thorson, Ph.D., related that at the University of Michigan CoE, 1991 data revealed an 11 percent unexplained differential in salary, but by 1995 the difference was no longer statistically significant. To set up a data collection system similar to the one used at the University of Michigan, it is necessary to first decide what categories will be covered. To keep the data clean, it may be best to not include, for example, chairs and past chairs, who may have inflated salaries, or faculty in various off-campus centers. It is then necessary to sort faculty by basic science versus clinical department, and next by department (or both divisions and sections) and faculty track, including degree (M.D., Ph.D.) and rank (assistant, associate, full professor). Women may not be in all cells; what is wanted are comparison groups. Next, it is necessary to make a time-in-rank (TIR) adjustment (based, for example, on a four percent increase per year). Salary components—base salary and academic supplement, which make up an academic salary, plus clinical support (both group and individual)—should be included, as should any lump sum amounts dispersed at the department's discretion to both men and women. If the results show salaries that are truly equitable, they will show that women are paid more half the time, and men more half the time.

Partnerships and Alliances

The Partnerships and Alliances track included five workshops focused on a variety of strategies and structures for building and sustaining responsible, effective involvement in long-term growth in communities and leadership.

The goal of **"Collaborating With Communities Through Alliances and Advisory Boards"** was to provide an overview of the structure, function, operation, and evaluation of various models of community alliances and advisory boards. Workshop objectives were to briefly characterize the integration of community alliances / advisory boards into CoEs; compare and contrast different models of community alliances / advisory boards; briefly describe strategies for evaluating their effectiveness; and present survey results on the use and function of such partnerships by Centers nationally.

Sharon Jackson, Ph.D., from the Wake Forest University School of Medicine CoE, presented the results of a national survey of CoEs to determine how partnerships and structures were formed and maintained. The main goal was to bring out new ideas and innovations to facilitate Centers' involvement and to embrace change. The results were as varied as the cities they represented.

For this project a survey of six questions about alliance-building was mailed to all CoE Center Directors. Of the 18 contacted, 13 (72 percent) responded; nine had set up boards / alliances. Of the nine, five used an advisory board structure, two use alliances, and two use both. One Center without a board participated in a community collaborative partnership with representation from a variety of groups and interests.

Regarding frequency of meetings, five of the nine Centers convened either semiannually (3) or annually (2). Two Centers met only to work on special tasks or projects. One met bimonthly, another quarterly, and no group met on a monthly basis. Representation was diverse—regarding race, ethnicity, and discipline—and based on a reciprocal relationship.

Activities were also diverse and depended on whether the group was an alliance or a board. Some focused on fundraising, others on conducting health fairs, creating marketing strategies, still others on service improvement by acting as a quality task force. Some reviewed CoE materials and programs, worked on joint projects with other groups and conducted community presentations and outreach. The alliances and boards were integrated into the CoEs in formal or informal ways.

Cindy Moskovic, M.S.W., from the University of California at Los Angeles (UCLA) CoE, outlined the objectives for developing a community alliance, which were focused on the diverse needs of the community and UCLA faculty. They included developing a group of interested consumers to provide feedback and to develop a network to advance women's health. The components included establishing community and grassroots

organizations, using an open enrollment status, convening quarterly meetings, and having group activities.

Membership includes representation by issue, organization, and racial and ethnic diversity. Included, for example, are women's health organizations, the Los Angeles (LA) County Board of Supervisors, domestic violence organizations, UCLA groups, and clinical facilities. Activities ranged from developing a community resource directory to eliciting feedback for the DHHS Office on Women's Health, regarding appropriate health care for women in the LA community.

Benefits that accrue to the community are networking between and among each other, voicing community needs, receiving the latest information on women's health studies, and limited individual consultation. In return, UCLA keeps its finger on the pulse of LA's diverse community needs, can market its programs through the Alliance, and obtain knowledge of community resources. Some strategies conducive to successful alliance-building are making meetings non-burdensome, requiring no additional financial outlays, providing pertinent, quality presentations, and having a group-directed agenda.

Cynthia Livingston, M.S.W., from the CoE at MCP Hahnemann University, provided a rationale for developing boards, which is to:

- Identify community needs;
- Obtain ongoing feedback;
- Contribute to the community's improvement (empowerment);
- Cooperatively plan projects and services; and
- Build good will.

MCP Hahnemann employs project-driven boards which have the advantages of providing intense, focused communication opportunities, addressing the specific needs of a group, and minimizing distractions. Disadvantages are that they are smaller in number (10 or fewer), are labor intensive, and considered less "newsworthy" in the mainstream press. Project-driven boards have been formed in four communities: African American, Asian American, Latino, and Arab American.

Marcia Killien, Ph.D., from the University of Washington, Seattle, CoE, focused on formal and informal methods for evaluating alliances and boards. She offered several suggestions in the form of questions for

coordinators and directors who either plan or participate in formal or informal evaluations. She also noted that there are different models for boards: project-specific and traditional advisory. In determining which model to pursue, it is necessary to ask the following questions:

- What is the staffing needed to maintain the model?
- Is it cost effective?
- If people do not attend, why not? Is it not valued?

Whenever possible, organizations should serve as consultants to advise on how to increase participation.

"Working With the Media: Balancing Marketing, Advocacy, and Scientific Agendas" was designed to demonstrate successful strategies used by three CoEs to work with the media. The session was moderated by *Carol Krause*, Director of Communications for the DHHS Office on Women's Health.

Pamela Perry, from the CoE at the Indiana University School of Medicine, provided a blueprint for conducting public awareness campaigns. Her presentation included information on how to help her CoE achieve recognition. Some strategies were to:

- Network with other PR professionals, community organizations / members, and news media contacts;
- Capitalize on assets within the Centers of Excellence;
- Understand where people get their health news (not from health care providers!);
- Identify traditional and non-traditional news outlets;
- Get your message across;
- Learn to conduct a news interview;
- Have a good sense of media and community relations; and
- Understand budget issues.

Tanya Ozor, from the Magee Womens Hospital CoE, delivered a presentation entitled, "Women's Health 911: Selling the Emergency." She outlined the four "C"s for selling an emergency in women's health. They are to:

- Communicate crisis. Let the media know there is a war to be fought. One way to convince them that it is a crisis is to hold a press conference that is attractive and demanding. It must offer food and either a national figure or the first person to uncover the newsworthy idea / product.
- Collaborate for solutions. This is not just self-serving. It is to let the audience know that all are advocating for the community. Put a human face on it and think about the faces at the table.
- Celebrate success. Send notes and flowers to thank them and note that the story effected change.
- Continue communication if appropriate. This serves as a follow-up with journalists later to check in on more story ideas or just to be in touch.

She stressed that every contact with the media has two purposes: advertising and advocating.

Shellie Ellis, M.A., from the Wake Forest University Baptist Medical Center CoE, discussed the media's power in improving or harming the public health. To "build a better watchdog" in which journalists better serve the public, they need to uncover the competing interests of their sources and better understand the research process. Journalists need to develop skills to distinguish between the truth and "trash." In order to help journalists achieve this, Wake Forest developed a training workshop for the media. Critical elements of research were addressed, including study designs, outcome measures, and a statistics course is offered. Ethical issues related to bias and conflict of interest were detailed for participants and case problem exercises are presented. The course has been rated highly on relevance to work. Journalists published stories on the research process to educate readers. Future plans include seeking funding for a substance abuse media series, for additional women's health media training, and for training in other areas.

"The Next Generation: Women's Health Researchers for the New Millenium" presented ways to attract youth to careers in women's health; showcased successful model programs and explored programs that did not work and why; and discussed funding possibilities for such programs.

Paula Gregory, Ph.D., from the Ohio State University CoE, described several programs to encourage young women. Through "Moms in Medicine," female high school students, undergraduates, and medical

students are invited to speak with women in medicine who have children and ask questions about what it is like to combine a medical career with motherhood. This has been an inexpensive, successful program. Another program, "Science in the Cinema," is designed to show popular movies with a health theme (e.g., "Outbreak") to the general public. Following the movie, a doctor discusses with the audience what is real and what isn't. A summer program that involves medical students in research is also conducted; however, recruitment must be improved.

Gloria Seelman, M.S., from NIH's Office of Science Education (OSE), works with high school and middle school students to increase understanding of women's health issues and to encourage girls to consider health careers. The OSE uses a communications approach designed to appeal to younger girls. Materials include the OSE/Office of Research on Women's Health video and poster series which portray women as inspirational models. Current and future videos include "Women Are Surgeons," which highlights the experiences of three multicultural women surgeons, "Women are Pathologists," and "Women Are Researchers." She also described the Health Science Curriculum Online, which addresses topics such as cardiovascular disease, diabetes, and cancer. It consists of six stories that revolve around the lives of multicultural teenagers. Each story links to other sites and includes labs that students complete in the classroom.

Juliet Rogers, M.P.H., from the University of Michigan CoE, described how to create opportunities for undergraduates by educating them about women's health and by creating a women's health climate on campus. She stated that it is necessary to assess the environment, to generate interest, and collaborate. An innovative component of their strategy is the compilation of courses that can be used for undergraduate students to design their own major in women's health.

Gloria Hawkins, Ph.D., and *Stephanie Lent*, M.S., from the University of Wisconsin - Madison CoE, discussed two programs for high school students that seek to enlarge the pool of underrepresented populations in science and medicine. One is a summer Research Apprenticeship Program (RAP) and an 8-week NASA Sharp Plus Program focused on science and technology. Components of both programs include: academic enrichment, research, career exploration, and exploration of academic opportunities. Participants develop a portfolio, design a Web page, write a research paper, and prepare a research presentation or poster. Each is assigned a faculty mentor.

Mentoring, a key component, poses a set of challenges all on its own. It is necessary to select the mentors, match them with participants, and have realistic expectations. The project must be doable in both quantity and quality, and participants must understand its importance. It is also necessary to have regular meetings, make it a positive learning experience, and have fun.

"Building Trust with Communities: It Takes Commitment" sought to increase participants' understanding of issues, challenges, and strategies involved in developing community partnerships. Community-academic partnerships are essential in advancing excellence in clinical, educational, and research programs in women's health. Foundational to these partnerships is trust among participants. This session addressed issues, challenges, and strategies for developing effective community partnerships. The meaning and process of developing and keeping trust were discussed. Case examples of successful community-academic partnerships from several CoEs were presented. Principles underlying successful community-academic partnerships were proposed. Session participants had the opportunity to share experiences and pose questions to panelists.

"Designing and Building an Effective Web Site" sought to dispel some mysteries surrounding the Internet and the Web. It was designed to provide a solid understanding of how to build a basic Web site, including the creation process, team roles, associated costs, specific tools, and next steps. Session presenters discussed how graphic design, content, and navigational features facilitate the use of the best Web sites. A review of the basic principles of "permission marketing" sought to answer why users return repeatedly to the same sites for information. The "future" of the Web addressed database connectivity, message boards, chat rooms, and "push technology." The session also addressed how to evaluate the content and credibility of women's health resources on the Web. Presenters from the CoE at the University of California at Los Angeles, provided an overview of their Web site (www.med.ucla.edu/womens), which includes extensive resources. All of the information and links contained in the site are thoroughly researched to ensure their accuracy.

Community and Patient Education

The Community and Patient Education track offered four workshops that described innovative community- and women's health-based programs that reach diverse populations. Topics discussed throughout the workshops focused on creating more effective, innovative outreach

strategies within various populations, increasing community knowledge about women's health issues, and finding innovative partnership and funding strategies to enhance programs.

"Creating Community Education Programs for Women: The Successes and Opportunities for Reaching Out to the Community" brought together representatives from Community Education Programs at three CoEs—Wake Forest University, Magee Womens Hospital, and University of Pennsylvania—who provided comprehensive overviews of their respective programs. Presenters focused on the design and implementation of programming using the following key components:

- Identifying the learning needs of customers (i.e., community members),
- Developing plans for comprehensive programs based on those needs,
- Publicizing and marketing community education programs, and
- Evaluating and adapting to the changing needs of the customers.

Panel members and the audience expressed concern regarding the overall challenges of increasing attendance, seeking out new funding, finding alternative sites for delivering programs, and measuring health outcomes.

Alma Wilson, M.S., from the Wake Forest University CoE, outlined the basic approach to its program "Health at the Well." Aimed primarily at African American women in the surrounding university area, the program focuses on six topics of interest for two months each throughout the year and is offered through the public library. Using Web searches, books, articles, and knowledge of the community, the six topics chosen were heart disease, osteoporosis, Alzheimer's disease, diabetes, domestic violence, and breast cancer. Each topic was given two months—the first devoted to providing women's health information to participants, the second to creative applications of the information in daily living. For example, in January 1999, women received information on heart disease. The next month, a demonstration on "heart healthy soul food cooking" was provided for participants. Later in the year, a monthly information session devoted to osteoporosis was followed by a low-impact session on chair dancing to provide safe alternatives for doing weight-bearing exercise.

Public libraries were chosen as appropriate sites because they are free to the public, situated in the heart of the community, and provided a non-threatening, user-friendly atmosphere to stimulate discussion and other

forms of interaction. Marketing strategies included providing free resources such as monthly calendars, information distribution in churches and women's health centers, and compiling a mailing list.

Connie Feiler, M.S.W., from Magee Womens Hospital, noted additional programming innovations and challenges. Using the "Womancare" model, which incorporates and includes women in its design, women participants provided program staff with valuable directives on how they want to be treated in health care settings. They stated, for example, that they do not want to be "talked down do." Health care providers should give information but not make decisions for women. They also wanted more access to services—not just regarding physical location but also convenient hours. They requested an integrated comprehensive care approach; they did not want to have five different appointments to get their needs met. They also stated that care needs to be cost-effective and of high quality.

Ms. Feiler provided a comprehensive overview of how the programming was developed using the key components described above. Some ways for identifying needs are through focus groups and a review of the literature. Developing the program plan took into consideration the varying kinds of formal education delivered such as work site programs and training community members to provide services. Informal education consisted of telephone consultations and one-to-one classes. Marketing concerns were addressed through the organization's calendar, newspaper, ads, community event calendars, and direct mail.

At the CoE at the University of Pennsylvania's Penn Health for Women, some guiding principles applied to all populations are that women need to position themselves as leaders in women's health within the community and that healthy lifestyle promotion is important. Penn Health for Women offers a wide variety of educational programs on- and off-site, including disease prevention and community programs. A variety of innovative teaching methods are employed including nutritious, healthy cooking classes, women's health conferences, and "topic folders" on such subjects as menopause and osteoporosis. Its funding streams are institutional and departmental, and also includes special friends and benefactors.

The objectives of **"Meeting the Educational Needs of Non-English Speaking Populations"** were to define cultural competence for providers in the context of gender and specific community language needs; describe elements of "community assets mapping" to develop relevant educational

populations; and to identify sources for developing materials for non-English speaking populations.

Beth Dugan, Ph.D., from the Wake Forest University CoE, provided an excellent example of how listening to community women and trying to meet their needs can change the direction of an entire project. They began with a model for reaching low literacy Hispanic women and created a Hispanic Health Guide. They soon realized that there were not many older Hispanic women but rather younger women who needed a bilingual project director familiar with Mexican women's concerns. As literacy levels are quite low, pictures and/or symbols are used to convey meaning. The Health Guide may be redone using different vehicles and will be pilot tested in the community. The goal is to create a portable health record but more importantly to provide a tool or map for navigating the health system in order to protect health and quality of life.

Maya Hammoud, M.D., from the University of Michigan Hospitals, presented an overview of the Middle Eastern Women's Health Initiative. The reasons for such an initiative are that there is a large underserved community with few preventive health care practices in place. There exist multiple barriers to health care access such as language, culture, and transportation. Also special issues related to male physicians and female patients must be addressed. Program components include a steering/advisory committee, a health program summit, a women's clinic, a local resource center, an outreach program and health care provider education. Challenges are the lack of trust and limited English-speaking skills and the desire to withhold information from patients about their health conditions. Some resources include community health care providers, bilingual educational materials, interpreters, local churches and mosques, and local/national Middle Eastern organizations.

The final presenter, *Judith Nine-Curt*, M.D., from the CoE at the University of Puerto Rico, focused on the differing cultural systems and how cross-cultural communication depends also on understanding non-verbal language. One can never fully understand a culture without understanding the different rhythms and methods for communicating non-verbally as well as verbally within and across cultures.

"Using Information Technology to Connect With and Educate Patients and the Community" was designed to review methods to better educate the community, including patients and health care providers, on issues of women's health through the use of information technology. The primary vehicle noted for reaching and educating women is the Internet. These resources can be disseminated via information technology, e.g., via use of

a Web site and the establishment of specially-designed resource centers. Methods that can be put in place to evaluate the quality of that information were discussed in detail during an interactive session which included an Internet demonstration.

The final session, **"State-of-the-Art Resource Centers and Kiosks,"** provided another opportunity to use different kinds of technology to reach women with health care information. Health care resource centers and kiosks play a pivotal role in helping women, who are generally the health care decision makers in families, have access to information in the limited time they have available. The session was designed to: provide participants with an understanding of the day-to-day operations of centers / kiosks, consider ways to improve access among CoE educators to state-of-the-art resources and information; and hear lessons learned in the building and operation of centers / kiosks.

IN CLOSING

The first National Forum of the National Centers of Excellence in Women's Health brought together nearly 300 representatives from the Centers of Excellence (CoEs), other academic health centers, philanthropy, and the business sector; as well as State, regional, and national government representatives. For two days, participants shared ideas on how to implement a new vision of women's health that is based on an integrated, holistic approach. They shared innovative strategies for adapting to the dramatic changes underway in health care policy and financing, and explored ways in which women's health—and the CoE model in particular—can serve as a catalyst for changing the knowledge, practice, and teaching of health care in our nation.

As reflected in the many presentations made at the Forum, much progress has been made in women's health in the past century. But there is still a long way to go. The Office on Women's Health, DHHS, would like to thank all of those who helped make the Forum a success. We look forward to continuing our partnership with you to improve the health of women of all ages, races, ethnicities, and backgrounds, across their life spans.

APPENDIX 1: PRESENTERS

OPENING REMARKS

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and
Surgeon General

Wanda K. Jones, Dr.P.H.
Deputy Assistant Secretary for
Health—Women's Health

PLENARY A

National Centers of Excellence: Innovative Models for Advancing Women's Health

Nancy Milliken, M.D.
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Gynecology and Reproductive Sciences
Director
Center of Excellence in Women's Heath
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Margaret McLaughlin, Ph.D.
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Reproductive Sciences, and Cell Biology and
Physiology
University of Pittsburgh
Associate Director
Magee Womens Research Institute
Director
Center of Excellence in Women's Health
Magee Womens Hospital

PLENARY B

The Future of Academic Health Centers: The Role of Women's Health

Clyde H. Evans, Ph.D.
Vice President
Association of Academic Health Centers

Organizational Change in the Centers of Excellence in Women's Health: What Now and What Next?

Nancy Fugate Woods, Ph.D.
Dean, School of Nursing
University of Washington, Seattle

LUNCHEON ADDRESS

The Honorable Pat Schroeder, J.D.
President and Chief Executive Officer
Association of American Publishers

CLINICAL CARE TRACK

Creating Women's Health Care Centers: Diverse Models with Common Goals

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Laurel Dawson, M.D.
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Reaching Out: New Frontiers in Telehealth

Beverly Jones, M.D.
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Department of Psychiatry and Behavioral Medicine
Wake Forest University School of Medicine

Rebecca Crowley, M.D.
National Library of Medicine Fellow
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Michelle Gailiun, M.A., M.S.W.
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Branding and Marketing Women's Health Care

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Deborah Steberg, R.N., M.S.
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Financial Assessment: Proving Your Value to the Institution

Cynthia Litt, M.P.H.
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Robert Oye, M.D.
Professor and Executive Vice Chair
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University of California at Los Angeles

Deborah Linhart
Vice President
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Women's Health in a Primary Care Setting: An Interdisciplinary Approach in an Urban (New Orleans, LA) and Suburban (New Haven, CT) Setting

Myra Kleinpeter, M.D., M.P.H.
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RESEARCH TRACK

Multidisciplinary Research: What? Why? How?

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Federal Women's Programs: Been There; Done That; Now What?

Judith LaRosa, Ph.D., R.N., F.A.A.N.
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Funding for Women's Health Research: Foundation and Industry

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Measuring Patient Satisfaction

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Increasing the Participation of Underserved Women in Clinical Research

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Databases: A Method to Assess the Health Status of Women and a Tool for Research

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PROFESSIONAL EDUCATION TRACK

Utilizing Computers to Enhance Education

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Strategies for Integrating Women's Health in the Undergraduate Curriculum

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Models for Incorporating Women's Health into Post-Graduate Education

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"If you don't know me, how can you treat me?": Cultural Competency in the Curriculum of Medical Schools and Diversity Among Women of Color Related to Their Health Needs

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LEADERSHIP TRACK

Leadership Issues for Faculty Women of Color

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Computerized Mentoring: Using Information Technology to Advance Women's Careers

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PARTNERSHIPS AND ALLIANCES TRACK

Collaborating With Communities Through Alliances and Advisory Boards

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Working With the Media: Balancing Marketing, Advocacy, and Scientific Agendas

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The Next Generation: Women's Health Researchers for the New Millennium

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